Blueprint for OASIS Accuracy - 2007
Workshop Registration Form

Audience:
Home Health

Speakers:
Linda Krulish &
Debbie Chisholm

September 18, 2007
8:00 am - 4:00 pm

Before August 17: $325
After August 17: $375
Price includes registration fee, workshop manual, and breaks

Workshop Objectives

1. To support education needs of home health clinicians in achieving comprehension & accuracy in OASIS data collection using guidelines established by CMS.
2. Introduce OASIS PPS data set changes.
3. Provide preparatory review for candidates for the COS-C (Certificate for OASIS Specialist-Clinical) examination.

Registration Information

To ensure your spot at this very important workshop, please fill out the information below, completely, and fax or mail to MHA, Attn: Jennifer Wagner.

NOTE: This registration form does NOT register you for the COS-C Exam. You must register for the exam separately by going to www.oasiscertificate.org or filling out the Exam Registration Form enclosed with the brochure.

☐ **YES!** I wish to participate in this workshop. I understand I am registering for the workshop only, and must register directly with the OASIS Certification Board for the exam. Fees will be refunded only if written cancellation is received by MHA by 5 pm on September 3. No refunds will be given after September 3.

Participant Information

Name:_____

Facility Name:_____

Email Address:_____

Facility Address:_____ ***City:***_____ ***State:***_____ ***Zip:***_____

Phone:_____ ***Fax:***_____

Payment Information

Payment Due: $_____

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number:_____ Expiration Date:_____

Cardholder Name:_____

Billing Address for Credit Card:_____

Signature_____

☐ A check, payable to MHA Ventures, Inc. is being mailed to P.O. Box 5119; Helena, MT 59604-5119

☐ Please invoice me - MHA Member Facility PO #: _____

For internal use only: Date Paid:_____ Registration Entered (date): _____ by: _____
Confirmation Sent (date):_____ by:_____
☐ Check #:_____ Check Amt:_____
☐ Invoice PO # Sent (date): _____ by:_____

MHA An Association of Montana Health Care Providers
P.O. Box 5119 Helena, MT 59604
Contact: Ph (406) 457-8006
Carrie Krepps carrie@mtha.org